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ABSTRACT

The record of practice in general medicine and primary care by osteopathic physicians of the U.S. is outstanding. The number of D.O.'s in the U.S. totals about 14,000 of whom some 13,000 are estimated to be active. Over 2,600 D. O.'s hold a current practice license in Florida but only about one quarter of these are presently living in the state. Osteopathic physicians tend to cluster around osteopathic hospitals, of which there are 17 in the state. The separate status of osteopathic and allopathic physicians shows many signs of disappearing. The cost of educating an osteopathic physician is quite similar to that for the M.D. since educational requirements are hardly distinguishable. The actual costs will vary somewhat with location and availability of existing resources, physical and professional. One point of unresolved difference between the two medical organizations involves the length of preparation for general/family practice. M.D.'s need 3 years of post-degree residency for certification; D.O.'s now require only 1 year of post-degree training. A lapse of some 7 to 10 years must be expected between authorization of any new school and the beginning of practice by its first graduates. (Author/PG)

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PHYSICIAN MANPOWER IN FLORIDA

SERIES

III. The Role of Osteopathic Medicine

STATE UNIVERSITY SYSTEM of FLORIDA

Office of the Board of Regents
Tallahassee, Florida 32304
February 1974

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U.S. DEPARTMENT OF HEALTH EDUCATION & WELFARE NATIONAL INSTITUTE OF EDUCATION

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Summary

The record of practice in general medicine and primary care by the osteopathic physicians of the U.S. is outstanding. This may be attributed to a number of factors, all of which should be carefully examined in this day of recognition of need for expansion of this area of practice.

The number of D.O.'s in the U.S. totals about 14,000 of whom some 13,000 are estimated to be active. Over 2,600 D.O.'s hold a current practice license in Florida but only about one quarter of these are presently living in the state. The number of active practitioners in Florida is somewhat under 700 compared with nearly 11,000 M.D.'s.

Osteopathic physicians tend to cluster around osteopathic hospitals, of which there are 17 in the state. Only half of these are fully approved for Medicare patients and only three (Miami, Miami Beach and Largo) are approved for housestaff. Thus approval is for a total of 25 interns and 13 residents. At present 15 internships and 8 residencies are filled.

The separate status of osteopathic and allopathic physicians shows many signs of disappearing. Hospital staff privileges and local medical society membership understandably increase the practice attractiveness of localities to D.O.'s.

The cost of educating an osteopathic physician is quite similar to that for the M.D. since educational requirements are hardly distinguishable. The actual costs will vary somewhat with location and availability of existing resources, physical and professional, but in general may be expected to be:

A. Physical facilities: $25 to $50 million.

B. Operating costs: $15,000 to $20,000 per student per year at full operation; much higher at outset.

One point of unresolved difference between the two medical organizations involves the length of preparation for general/family practice. M.D.'s need three years of post-degree residency for certification. D.O.'s now require only one year of post-degree training plus "commitment to continuing education." This requirement may become two years soon.

A lapse of some seven to ten years must be expected between authorization of any new school and the beginning of practice by its first graduates.

KEP:cl

PHYSICIAN MANPOWER IN FLORIDA

III. The Role of Osteopathic Medicine

Osteopathic medicine owes its origin largely to one man - Andrew T. Still. Dr. Still (1828-1917), son of a Missouri frontier physician/preacher who went West as a missionary, received an above average medical education for his day and served as a Union Army doctor during the Civil War. He seems to have been a nonconformist by temperament and made known his dissatisfactions with conventional medicine. His own studies in anatomy, physiology, chemistry and mineralogy led him to develop a number of new theories, primarily based on mechanical disorder and imbalance in body structures.

It was not surprising that opposition to the ideas of Still would arise, especially since acceptable scientific proof of those theories was not forthcoming. The majority of organized medicine rejected completely his teachings. Yet, his demonstrated success with patients continued to attract many followers.

The first school organized to teach osteopathic medicine was established in Kirksville, Missouri in 1892. Six other schools are now in operation - at Chicago, Des Moines, Kansas City, Philadelphia, Fort Worth and Lansing, Michigan. The latter two have been recently established - the older five date back to the early 1900's. An eighth school is currently in development - a freestanding institution as part of the State University System of Oklahoma in Tulsa. (In 1962 the California College of Osteopathic Medicine and Surgery was converted to an M.D. degree granting institution and became the University of California School of Medicine at Irvine.)

For proper perspective it must be recalled the period of origin of osteopathic medicine coincided with a time of considerable turmoil and lack of standards in all of medical education. At the time of the Flexner Report (1910) there were 160 so-called medical schools in the U.S., two-thirds of which later folded or were reorganized in the process of medicine's own housecleaning.

Osteopathic medical schools did adopt many of the principles of Flexner reform, but continued to develop a separate, parallel system. A fundamental difference in the two systems was in their relation to universities. All of the osteopathic schools continued as free standing privately supported institutions whereas only a scattered few of the M.D. degree granting institutions failed to establish a university base. The separate structure spread through the profession and led to the formation of American Osteopathic Association (AOA)--American Medical Association (AMA) counterparts, with similar but totally separate structures and functions, including jurisdiction over the content of the education programs of their respective medical schools.

With only a few schools, and those small and largely impoverished, the ranks of the osteopathic profession have not grown rapidly. But the separateness prevailed, more so in some areas of the country than others.

By the 1930's hospitals were rapidly coming into greater use in the care of patients. As a result of internecine conflict in most areas of the country D.O.'s were denied hospital privileges in institutions dominated by M.D.'s. This encouraged the development of separate osteopathic hospitals in those areas where resources could be promoted--as often as not through wealthy patients who had been successfully treated and became strong supporters. It was natural, then, that osteopathic physicians tended to establish their practice in the proximity of an osteopathic hospital. This has led to an uneven distribution of D.O.'s throughout the U.S., and also within states.

The principal factor that brought about separate development of the two branches of medicine in the first place--musculoskeletal manipulation--has lessened in importance in the practice of a great many D.O.'s.

In the performance of much of patient care the methods and techniques of the two kinds of physicians are largely indistinguishable. Both use the same or similar diagnostic techniques and resources, prescribe essentially the same remedies including drugs, and even duplicate many highly refined specialty categories.

A common criticism of the manipulative theory associated with osteopathy is that no scientific proof exists to justify it. Dean Myron Magen of the Michigan State University College of Osteopathic Medicine readily admits the profession has been at fault for failure to establish a more firm research base but points out that the lack of clear understanding of how they work in the body has not prevented the medical profession from adopting aspirin, penicillin and a host of other drugs. He adds, "We find, and we attempt to point out to our students, that even though we don't know particularly how manipulative therapy may work in a given situation, manipulative theory per se is no more and no less empirical than psychiatry."

For whatever reason, there can be no denying that manipulative therapy has attracted a sizable number of supporters among the patients to whom it has been administered.

Until recently little if any closure of the void between the AOA and AMA organizations was apparent. Indeed relations were severely strained a decade ago by the California College of Osteopathic Medicine and Surgery conversion to the M.D. ranks leaving no trace of its heritage.

Signs of rapprochement are now clearer than they have ever been. In part this is probably due to the increasing number of D.O. graduates who have found their way into M.D.-approved internships and residencies and by their performance have gained respect for their preparation in medicine. In any event a growing number of M.D. dominated hospitals and medical societies are opening their ranks to D.O.'s.

Osteopaths are somewhat less enthusiastic about reconciliation than are M.D.'s. They understandably do not wish to see their disproportionately small ranks (13,000 vs 356,000)* consumed.

Somewhat fortuitously another factor has now surfaced which could contribute significantly to improved working relations. In response to public demand M.D. education is now turning strongly to primary care and family practice. These are the areas of care in which osteopaths have made their greatest mark.

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*As of 31 December 1972. AMA Department of Health Manpower Records.

Currently accepted figures show nearly three quarters of the D.O.'s in the U.S. in family practice as opposed to only 17.9% of the M.D.'s.* The national structure of osteopathic medicine does provide for specialty preparation in parallel with its sister structure for M.D.'s having 13 American Osteopathic Specialty Boards (one of which is General Practice).

The point is occasionally made that a major factor contributing to the high proportion of D.O.'s in general practice has been lack of opportunity to specialize. There could be some truth in this inasmuch as it is readily admitted that specialty residencies have traditionally been scarce and competitive. The number and size of osteopathic hospitals has always been small and the AOA has not accepted specialty training that was obtained entirely outside of the D.O. structure. (Rules on this appear to be undergoing relaxation and acceptance of parts of such training by M.D.'s varies with AOA specialty boards.)

A more likely contribution to the family practice orientation of D.O.'s is the structure of the curriculum and the conduct of the osteopathic medical schools. From selection of students to the required rotating internship (by all specialty boards) the emphasis is, and has always been, on family medicine. When the teaching of M.D.'s was moving into the tertiary care medical centers such large institutions were not available to D.O.'s. The role model remained--and is-- the family physician.

The D.O. Curriculum

Curricula among schools of osteopathic medicine vary almost as widely as do those among the M.D. schools. Chicago College of Osteopathic Medicine is an example of a conservative, traditional approach. There the primary clinical experience of the student is in the OPD where he serves in the role of the family physician. His exposure to specialists is primarily in connection with patient referrals, but short clerkships in the clinical specialties are a part of the last year. The program spans four years, the fourth year is 50 weeks, and the total is approximately 4500 required clock hours of instruction, plus electives.

The new college at Michigan State University has adopted a 33-month, 3-year curriculum designed around integrated teaching concepts. The first year student begins with didactic courses in anatomy and physiology but also is introduced to physical diagnosis and a preceptorship at the outset. There are only three clinical departments--Family Medicine, Community Medicine and Osteopathic Medicine. Community Medicine offers one sequence of didactic courses titled Health Behavioral Sciences and a second called Health, Medical Care and Society. Many departments and individuals contribute to these sequences. The Department of Osteopathic Medicine conducts a course in Medical Biology with contribution by the basic science departments. It also has a second series called Systems Biology which likewise integrates teaching from other departments and specialties.

While differences in emphasis stand out, and especially the attention to family practice among osteopathic schools, the requirements for entry, the total time spent in medical school, and the extent of clinical experience with patients are quite similar between the M.D. and the D.O. educational programs.

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*As of 31 December 1972. AMA Department of Health Manpower Records.

The total number of graduates from six osteopathic colleges* in the U.S. in 1973 was 647. It is anticipated to be 615 in 1974 and 694 in 1975. These numbers do not indicate that Florida's ranks are likely to be affected much by the output of D.O.'s from existing schools. Many osteopaths would like to see the establishment of more new schools of osteopathic medicine, including one in Florida.

If Florida were to undertake the development of a new school of osteopathic medicine in order to increase the supply of family practitioners in the state it would appear there are three options to be examined:

1. Develop a new school associated with one of the existing M.D. granting schools.

or 2. Place a new school on a campus of a State University System school not now having a medical school.

or 3. Encourage the development of a private school--free standing or associated with a private university--with state financial assistance in the pattern of the arrangement now in effect with the University of Miami School of Medicine.

Michigan State University offers a prototype for study of Option 1. There the College of Osteopathic Medicine is located alongside the College of Human Medicine (M.D. granting) and the College of Veterinary Medicine. Basic science departments are common to all three, as are all campus resources, but these do not include a university-owned hospital. Both the M.D. and the D.O. schools depend upon external clinical resources in several communities geographically widespread and some at considerable distance.

Students in the M.D. and D.O. programs at this time commingle only in pathology, but they have shared other courses in the past and such is planned for the future. This is because of curricular logistics rather than any philosophical exclusion. The basic science departments declare that they do in fact provide common course content and did in the recent past teach some subjects to mixed classes with good results. They deny any evidence of a marked superiority of one group over the other. As of now both schools share a common Department of Psychiatry which all seem to agree works well. In addition there is some further crossover of clinical faculty and training--including elective exposure to manipulative techniques by some of the M.D. students--but this is limited because the clinical teaching is largely provided in scattered communities, and in separate hospitals, clinics and offices.

There seems to be widespread agreement at Michigan State University that there are advantages to having M.D. and D.O. schools together but saving substantial sums of money is not one of them. Basic science departments are large, diverse, and carry a very large teaching load. They feel, however, that there is greater total strength through this arrangement than would result from replicated smaller departments. Largeness permits staffing with a great diversity of talents and recruitment of quality staff is said to be enhanced by the attractions of joining such an array of talent. While single departments may provide some minor savings in space and equipment, if each school must have separate teaching there is little if any saving in FTE-generated faculty.

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*The College at Fort Worth, Texas will graduate its first class in 1974.

The administrative and, for the most part, supportive staffs of the two schools are separate. Each must report to a different professional and accrediting organization. On the plus side, a unique opportunity is provided a department of medical education research and development to carry out many worthwhile studies which may contribute greatly to better understanding of the two branches of human medicine in the future.

The question is sometimes asked why not combine the schools with electives available to permit option of the M.D. or D.O. degree. While this may sound attractive in theory it is impractical at this time for, as previously mentioned, the M.D. and D.O. schools are responsible to separate accrediting bodies who quite likely would not accept such an arrangement. In addition, at least at present there is a wide difference in curricular philosophy and structure especially with regard to emphasis on general practice.

Locating a new D.O. school alongside one of Florida's existing M.D. schools would appear to offer advantages such as:

A. Better basic science instruction through further strengthening of existing departments.

B. Use of common library facilities.

C. Better rapport and understanding between faculty, staff and students of the two schools.

D. The new school would have the intangible advantages of a parent university with experience in the operation of a medical school.

Such location would have serious disadvantages for clinical instruction. As noted, the educational programs of M.D. and D.O. schools are accredited by totally separate bodies, each relating in some degree to its practicing professional organization. Osteopathic clinical education must, at this time, be conducted almost entirely by D.O.'s, and in D.O. facilities.

Additionally, while the affiliation appears to be working well at Michigan State University there is common agreement this success is largely dependent upon the personalities and outlook of a few key administrators, the fact both schools began at almost the same time and are growing together, and certain well established traditions at that university such as multiple school service of single departments. Caution must be exercised in the presumption of the extent the MSU experience is transportable.

Regarding Option 2, Michigan State University College of Osteopathic Medicine is the first and to date only D.O. granting school to be part of a university campus. As in the case of M.D. granting schools, not everyone is convinced of the great advantage of such arrangements although the preponderance of evidence appears to favor affiliation.

The primary point of articulation of medicine with its parent university is in the science departments--biological, physical and social. The potential of these relationships often exceeds reality, at times to a considerable degree. For maximum value to result, a D.O. school would need to become a part of a university already possessing strength in its science areas, especially at the graduate level. Medical education is unmistakably graduate level and departmental relations within a university tend to reflect this. In view of the

present state of development of the several campuses of the State University System, the potential for meaningful addition of a D.O. school is limited.

The Chicago College of Osteopathic Medicine (CCOM) presents a prototype of Option 3, the free-standing school receiving state subsidy (Philadelphia College of Osteopathic Medicine likewise is state assisted). The principal trade-off is that CCOM enjoys the benefit of a unified physical location including extensive clinics and hospitals, which allow the entire teaching program to be both integrated and, for the student's benefit, at one location. That location provides a wealth of patient material (except perhaps for a limited socio-economic spread).

Florida was one of the earliest states to adopt the practice of tax assistance for private professional education. Since 1952 a subsidy has been paid the University of Miami School of Medicine based on the number of Florida residents enrolled in its classes. This subsidy at present amounts to $8,500 per student for 3 years or a total of $3,400,000 in the present fiscal year.

This arrangement affords certain advantages to the school to seek additional resources that would not normally be available to a state owned school. On the other hand it generally results in some penalty to the student in that he is faced with the payment of a substantially higher fee than is the case at a tax supported school.

Osteopathic Medicine in Florida

The American Osteopathic Association Yearbook and Directory of Osteopathic Physicians showed in January 1973 a total of 11,074 members of the AOA and 3,015 non-members for a total of 14,089 D.O.'s.

For Florida the January 1973 listing showed:

774	Total D.O.'s with Florida addresses
23	Were interns (15) or residents (8)
121	Were shown as retired
630	Thus were presumed active
350	(56%) Were listed as general practitioners
145	Indicated a specialty but do not limit to that
135	(21%) Limit practice to a specialty

Data from the office of Dr. Meck, Executive Director of the Florida Board of Osteopathic Medical Examiners for 31 December 1973 are as follows:

730	Currently licensed D.O.'s in Florida
1887	" " " not in Florida
2617	Total holding current license.

Not all of the 730 current license holders in Florida are in active practice; but the number of retired , or semi-retired, D.O.'s who keep up their license is unknown at this time.

Previous reference was made to the separate osteopathic hospital development in the U.S. and their importance in the geographic location of D.O.'s. In Florida at the present time there are 17 osteopathic hospitals as follows:

In the osteopathic structure the AOA has responsibility for accreditation of their hospitals rather than the Joint Commission on Accreditation which oversees all others. Certification of standards must be supplied the Federal Government to establish eligibility for Medicare payments. Only nine of the 17 Florida osteopathic hospitals are so accredited and they are identified with an asterisk(*).

		BEDS
CARRABELLE GENERAL Carrabelle	25 adult	6 newborn
COMMUNITY Hollywood	282 adult	
*DAYTONA BEACH GENERAL Holly Hill	205 adult	
*DOCTORS GENERAL Plantation	143 adult	4 newborn
DOCTORS St. Petersburg	150 adult	
GOOD SAMARITAN OF TAMPA, INC. Tampa	63 adult	5 newborn
JACKSONVILLE GENERAL Jacksonville	104 adult	
*LAS OLAS GENERAL Fort Lauderdale	64 adult	
*METROPOLITAN GENERAL HOSPITAL INC. Pinellas Park	58 adult	3 newborn
NORTHWEST Miami	27 adult	
*ORLANDO GENERAL Orlando	97 adult	6 newborn
*ORMOND BEACH Ormond Beach	81 adult	
*OSTEOPATHIC GENERAL North Miami Beach	269 adult	6 newborn
*SUN COAST Largo	236 adult	6 newborn
TAMPA OSTEOPATHIC Tampa	73 adult	8 newborn
WEST BROWARD Fort Lauderdale	28 adult	7 newborn
*WESTCHESTER GENERAL Miami	100 adult	
TOTAL	2005 adult	51 newborn

In addition the AOA approves certain hospitals for internship and residency training. At present only three hospitals in Florida are so approved:

OSTEOPATHIC GENERAL		
North Miami Beach	10 interns	10 residents
SUN COAST		
Largo	10 interns	3 residents
WESTCHESTER GENERAL		
Miami	5 interns	

There were 15 interns and eight residents on duty in these hospitals in January 1974.

By contrast, Michigan has 170 approved internships and 324 residencies. Texas and Oklahoma, the sites of the other developing new schools, on the other hand have 24-18, and 21-22 approved internships and residencies, respectively.

The distribution of licensed D.O.'s in Florida follows closely the hospital locations.

The ten Florida counties with the greatest number are:

County	D.O.'s	Number of Hospital Beds
Dade	158	402
Broward	141	528
Pinellas	141	453
Volusia	43	286
Hillsborough	39	149
Orange	35	103
Palm Beach	23	-
Duval	23	104
Pasco	14	-
Sarasota	9	-

(All other counties have seven or less D.O.'s.)

If osteopathic clinical medicine teaching is to be carried out by osteopaths in osteopathic hospitals approved for internship and residency instruction, the potential sites in Florida are limited. This was pointed out clearly by Mr. Lawrence Mills in a report submitted 23 February 1972 to the Florida Osteopathic Medical Association. He noted only two approved osteopathic teaching hospitals already exist in the Miami area: Osteopathic General and Westchester General - and suggested that the others in that area should take steps to apply for approval.

He stated, "With over 600 potential teaching beds in the area near the North (Interama) Campus of Florida International University, it is quite easy to project a College of Osteopathic Medicine in that vicinity, university affiliated, with State and Federal support."

Mr. Mills' study did not attempt any in-depth analysis of the capabilities or readiness of Florida International University to undertake the development of such a new school, nor the likely costs involved.

If the option to start a new school to produce osteopathic physicians were to be selected the costs involved should be carefully projected. There is no reason to believe that such costs should be any less--or any greater--than those associated with development of a new M.D. granting school of comparable size. The programs of M.D. and D.O. schools are so comparable in length, courses and hospital use as to underscore the similarity of cost.

The Michigan State University College of Osteopathic Medicine may again be used as a prototype experience. The beginning of that school was a bit atypical in that it enrolled its first class as a private school in Pontiac in 1969. That same year the bill was passed by the Legislature making it a part of MSU and the first class of the state-supported school was enrolled in 1971. The number of graduates (D.O.'s) now projected by year is as follows:

	Number of Graduates	Cumulative
1972-73	42	42
1973-74	30	72
1974-75	72	144
1975-76	75	219
1976-77	83	302
1977-78	84	386
1978-79	99	485
1979-80	100	585
1980-81	105	690
1981-82	105	795

For the first ten graduating classes, with a cumulative total of 795 graduates, the sum of the annual operating budgets is projected to be $50.35 million. This does not include capital outlay. These budgets are conservatively projected without inflation or salary increments and begin with the year of graduation of the first class, not the year of beginning development of the school. During those years the 795 graduates might be figured to cost $63,000 each. However, more sophisticated cost allocation has led MSU to state, "The per graduate cost is calculated to decrease from $40,000 in 1975-76 to $14,285 in 1983-84."

For comparison, the new medical school at the University of South Florida will graduate its first students in 1974-75. Its current projections are:

	Number of Graduates	Cumulative
1974-75	48	48
1975-76	36	84
1976-77	64	148
1977-78	96	244
1978-79	125	369
1979-80	125	494

The capitol outlay for South Florida's Medical School will be about $26.0 million. Operating costs according to a recent AAMC study indicate $15-25,000 per student per year.

Costs of operation might be expected to vary considerably with the location, and relationships, of a school in Florida.

Osteopathic medical education has been characterized by a substantial involvement of volunteer, practicing clinicians and lower full-time-faculty-to-student ratios than are traditional in M.D. schools. In addition, the record of financial support of education by members of the profession has long been excellent. At present the Florida Osteopathic Medical Asscciation is providing subsidy to those schools in which Florida residents are now enrolled.

One final point should be made in connection with the development of a new school. Some pre-planning is necessary before admission of the first students. As of this time, three years is a minimum time in medical school before the degree is awarded. Then at least one year of rotating internship is required of the D.O. before he may obtain a license to practice in Florida. At least one additional year of residency is required for General Practice Board eligibility. Other specialty boards generally require three years of residency training beyond the rotating internship. It seems clear that from the time of authorization of a new school to the time of beginning practice of its graduates some seven to ten years must be expected and a period of 12 to 15 years will be necessary for any significant numbers of graduates.

KEP:cl

AMERICAN ASSOCIATION OF COLLEGES
OF OSTEOPATHIC MEDICINE

4720 MONTGOMERY LANE, SUITE 609, WASHINGTON, D. C. 20014 301 — 654-5600

February 1, 1974

COMMENTS ON "PHYSICIAN MANPOWER IN FLORIDA--III.
THE ROLE OF OSTEOPATHIC MEDICINE"

Comments from AACOM fall into two general categories.

I. Considerations of Organization and Administration:

1. Consideration should be given to alternative models of a freestanding and independent college of osteopathic medicine. Conceivably, such a school could be related to an existing university or affiliated with the state university system. This concept would open many additional possibilities in the state of Florida. At the same time, it is important to underline the value of a strong ambulatory care center as the backbone to the training of the family physician with, of course, adequate in-patient back-up capability. There is no way that the family physician can be trained in a hospital setting alone. The ambulatory care center must be located in an area where it will attract patients from a diverse socioeconomic background of the type who are attracted to an outpatient facility designed for training purposes. We feel this is necessarily a less affluent setting than exists in

some of the hospital settings.

2. Consideration should be given to the potential of attracting a markedly increased number of Florida students into osteopathic medicine by virtue of having a school in that state. Not only will the Florida students be attracted to the Florida College of Osteopathic Medicine, but the number of applicants to other schools of osteopathic medicine would double, triple or quadruple.

3. Among the hundreds of osteopathic physicians presently practicing in Florida are a great number who have had teaching experience on faculties of colleges of osteopathic medicine in the past. We're confident that a great number of these individuals would enjoy a return to the academic arena especially if they had an opportunity to be participants in the development of the educational process.

4. Every year of delay in the development of this college would mean the potential loss of dozens of primary practice oriented osteopathic physicians who could be taking care of people in the State of Florida.

II. Considerations of Philosophy and Objectives:

1. With regard to the following statement;

> The principal factor that brought about separation of the two branches of medicine in the first place--musculoskeletal manipulation--no longer provides such a sharp demarcation.

The demarcation may not be as sharp today as it once was, but it is still there (in broader context than musculo-

skeletal manipulation)-and it is still extremely important. Most M.D.'s do not place the same emphasis on the importance of somatic dysfunction or, utilizing another term, the somatic component of disease, as do most D.O.'s In the same vein, most M.D.'s do not have the same technical capability of recognizing and managing somatic dysfunction as do most D.O.'s The late Sir James Mennell in the monograph "The Science and and Art of Joint Manipulation"(1) wrote:

> An enormous amount of human disability and suffering is amenable to treatment by manipulation, even to the extent of cure.
>
> There are other conditions in which manipulative treatment can be of service in reducing disability to the minimum when without it the patient would suffer unnecessary disability or discomfort.
>
> There is no doubt that the final downward fall into complete incapacity can often be postponed in cases of incurable disease.

While Dr. Mennell's observations are empirical in nature, this certainly does not invalidate them. Thus, patients can receive services in the offices of most D.O.'s that are of major importance in many clinical problems, but that simply are not available in the offices of most M.D.'s

Dr. Janet Travell, whose experiences and insights parallel many of those of the D.O. group, has conclusively shown

(1) Mennell, James. The Science and Art of Joint Manipulation. Vol. 1, 2nd edition, The Blakiston Co., Philadelphia, Penn., 1949, page 215.

that somatic blockade, with local anesthetics, of disturbances (trigger zones) in the skeletal framework may have a profound, and favorable, influence on coronary artery insufficiency. In this same context, it would be a mistake to limit the usefulness of D.O. services to therapy since such services are equally important in diagnosis. Palpation of the soft tissues, which directly or indirectly overlay and support joints, when used by a physician skilled in this diagnostic procedure will reveal the presence, absence and to a substantial degree the severity of pathophysiologic disturbances (including hyperalgesia) in those tissues, regardless of whether the etiological factor is within the tissues themselves or whether it is reflecting pathophysiology on the basis of viscerosomatic or psychosomatic reflexes. Thus, there is a diagnostic procedure that is available to most D.O.'s and not to most M.D.'s which can be carried out quickly, and with no iatrogenic side effects.

2. With regard to the following statement;

> A common criticism of the manipulative theory associated with osteopathy is that no scientific proof exists to justify it.

Dean Magen's comment cannot be denied;

> We find, and we attempt to point out to our students that even though we don't know particularly how manipulative therapy may work in a given situation, manipulative theory <u>per se</u> is no more and no less empirical than psychiatry.

However, it cannot be said that the osteopathic profession

has been at fault for failure to establish a more firm research base. As the report points out, there are only a few osteopathic colleges and those small and largely impoverished. These colleges simply have not had the funds with which to secure the expensive talent and the technical and physical plant facilities which are required for major research programs. Attempts to secure such funds, which have been made by individuals, organizations, and institutions, have for the most part been unsuccessful.

Dr. James A. Shannon, when he was the Director, National Institutes of Health, discussed this situation with the following comment:

> The separation of osteopathy from the conventional medical degree granting institutions, that is setting these institutions apart as being two groups that may have the same overall objective but elect different routes to satisfy that objective, has been a serious disservice to the development of osteopathy.
>
> The restrictions imposed upon osteopathy by the AMA, by the American Hospital Association, in such things that relate to certification of hospitals, certification of hospital training, are such as to preclude a normal interflow of professional staff of stature between the conventional medical school and the conventional school of osteopathy.(2)

(2) Shannon, James A. Testimony Before Intergovernmental Relations Subcommittee of Committee on Government Operations of House of Representatives on "Health Research and Training". August 1-2, 1961, United States Government Printing Office, Washington, D.C.

These comments are made, not with a sense of recrimination, but instead to point out that deep-seated cleavages have existed, and continue to exist, between the D.O. group and scientific community in general, particularly the medical element in that community, and the sources of funding which support that community.

Along this same line the report states;

> While differences in emphasis stand out, and especially the attention to family practice among osteopathic schools, the requirements for entry, the total time spent in medical school, and the extent of clinical experience with patients are quite similar between the M.D. and the D.O. educational programs.

Obviously, at least by implication, the report does not recognize that there is an important curricular difference from the standpoint of emphasis between the M.D. and D.O. schools since, in the latter, there is a considerable emphasis on reversible pathophysiologic disturbances in the neuro-musculo-skeletal system, which is not found in the former.

3. With regard to the following statement;

> For whatever reason, there can be no denying that manipulative therapy has attracted a sizeable number of supporters among the patients to whom it has been administered.

We believe the following consideration should be added to the report:

There is the need to provide Florida with, not only primary care physicians, but also with phy-

sicians who can provide services to the public which most D.O.'s can and most M.D.'s cannot, perform. While there is no objective way to determine this, the number of requests by patients, not only in Florida but in other states, for names of doctors and hospitals from whom osteopathic services can be obtained, indicate that this need may indeed be as great as the need for primary care physicians.

Regardless of its popularity, and regardless of whether the State of Florida or any other location might be involved, it must be recognized that osteopathic medicine, if it is to make its maximum contribution to the health and well-being of the patients who are served by all of medicine, must have the funds with which to do the research that is necessary for scientific and technical growth.

Summary and Conclusions

of the Florida Health Planning Council
Health Manpower Committee, FHPC

OSTEOPATHY

Florida, with 3.7 percent of the U.S. population, now has 4.8 percent of the 14,000 D.O.'s of the U.S. living in the state. Some 18 percent of all D.O.'s hold a currently valid practice license in Florida but three out of four of these have not yet elected to establish a practice here. What are the factors which have caused over 2500 D.O.'s to obtain a Florida license but less than 700 to locate here?

It is apparent from the report that the availability of hospital privileges has a large influence on where osteopaths establish practice. An understandable cluster exists around the osteopathic-owned hospitals. Unfortunately, the number of non-osteopathic hospitals whose staffs welcome D.O.'s for privileges is limited. Significantly those hospitals that do welcome D.O.'s to the staff are predominantly in the medically well-served areas of the state rather than the underserved.

It would be of interest to know what effect opening hospital privileges in underserved areas of the state might have on increasing the attractiveness of those areas to the osteopaths holding a Florida license but not now living in the state.

In spite of the large number of D.O.'s who have obtained a license to practice in Florida, Florida's licensure mechanism is restrictive. Florida is one of twelve states with separate licensing boards for osteopaths and M.D.'s. In addition Florida's osteopathic examiners require a one-year rotating internship, "....in a hospital approved by the Board and by AOA." There are now many graduates of osteopathic schools electing M.D. internships that do not meet approval of the American Osteopathic Association. In those states with combined boards they would be eligible for licensure. In Florida they are not. This is particularly unfortunate in that there is evidence that some osteopathic graduates elect M.D. internships.

The need for more primary care physicians in Florida must be the cornerstone for consideration of the establishment of a new school of osteopathic medicine. But is Florida prepared to undertake such a move if it is determined that is the option of choice?

The nature and quality of osteopathic medical education differs little from that of the M.D. granting schools in the U.S. Indeed, it is no doubt superior to that available to many graduates of foreign medical schools who are licensed each year. But does Florida need another medical school at this time? Would expansion of existing medical education programs be a preferable route if more are needed? Those are basic considerations that must be faced.

In the establishment of the many new medical schools (M.D.) in the U.S. in the last decade, including the one at the University of South Florida, a fundamental consideration has always been the prior existance of a climate of education. This is best manifested in a vigorous internship and residency program ongoing in the area where a new degree granting school is to be established. This is important for at least two reasons: to provide a basic clinical education program in local hospitals on which may be grafted medical students, and to demonstrate the existance of a cadre of teaching-oriented practitioners in the area whose contribution to the medical school will be so vital.

Such a setting does not now exist in Florida. Teaching hospitals are few in number, scattered, and the number of interns and residents is small.

Much of the current effort to provide more primary care physicians is now directed at the internship and residency portion of medical education. Florida has a well organized program underway to increase the number of well prepared primary care practitioners, involving all three of the existing medical schools and many of the community hospitals. Unfortunately at this time osteopathic interns and residents are not participating in this program. Steps should be taken to include them, and to stimulate expansion of this phase of osteopathic medical education at once.

Emphasis on the graduate portion of osteopathic education has potential for earlier results at far less cost to the state, while at the same time improving the climate of medical education for possible future consideration of further expansion.

On the basis of the above discussion, and the data available, the Health Manpower Committee of the Florida Health Planning Council offers the following recommendations:

* The wording of the Community Hospital Education Act should be changed to permit support of approved osteopathic internship and residency programs as well as those for M.D.'s.

* Osteopathic hospitals should be encouraged to develop additional training programs and expand existing programs.

* All Florida hospitals and local medical societies should be encouraged to offer privileges and joint membership to doctors of osteopathic medicine and doctors of medicine.

* Under an appropriate timetable Florida should move toward the development of a common licensure board for doctors of medicine and doctors of osteopathic medicine.

* The capacity of Florida's medical education programs is such, and the in-migration of physicians is so great, that Florida does not need another school of medicine or of osteopathic medicine in the foreseeable future.

The above recommendations were adopted by the Florida Health Manpower Council on 5 January 197[illegible].

Conclusions and Recommendations

of the Florida Medical Association
Committee on Medical Education

With regard to the need for a school of osteopathic medicine, it is the conclusion of the FMA Committee on Medical Schools that this need should be considered entirely on a cost/benefit basis. It is the Committee's opinion that the supply of primary care physicians is increasing due to the interest of medical students in primary care medicine, the greater financial support provided by the federal government for such training, the recent expansion of the family practice programs offered at the University of Miami and the University of Florida and the innovative Program in Medical Sciences offered at Florida State University and Florida A&M University. The Committee feels that any additional state funding for training in primary care medicine should be expended through existing educational programs.

January 1974

Conclusions and Recommendations
of the Health Affairs Committee
to the Board of Regents
State University System of Florida

After much study of the pertinent data the Health Manpower Committee of the Florida Health Planning Council has concluded that Florida does not need another school of medicine or of osteopathic medicine in the foreseeable future. The Committee on Medical Education of the Florida Medical Association takes the position that any additional state funding for training in primary care medicine should be expended through existing programs. Even though the osteopathic physicians do not agree with the foregoing, it is the recommendation of the Health Affairs Committee to the Board of Regents that this Board concur with the conclusions of the FMA Committee and FHPC Health Manpower Committee. Florida does not need another school of medicine or of osteopathic medicine in the foreseeable future.

In order to obtain the maximum from all those trained and being trained to deliver primary care medicine in this state, it is recommended by this Committee to the Board of Regents that we support the following recommendations of the Health Manpower Committee of the FHPC.

* The wording of the Community Hospital Education Act should be changed to permit support of approved osteopathic internship and residency programs as well as those for M.D.'s.

* Osteopathic hospitals should be encouraged to develop additional training programs and expand existing programs.

* All Florida hospitals and local medical societies should be encouraged to offer privileges and joint membership to doctors of osteopathic medicine and doctors of medicine.

* Under an appropriate timetable Florida should move toward the development of a common licensure board for doctors of medicine and doctors of osteopathic medicine.